

MS STATE VETERANS AFFAIRS BOARD

3466 Hwy 80 East

P.O. Box 5947

Pearl, Mississippi 39285-5947

SOCIAL HISTORY

We have found through experience that the more we know about our residents when they come into our facility the better care we can give. Often details of a person's past life which we never thought of asking about turn out to be important factors in their happiness here. Your replies are completely confidential and will be used only for professional purposes. Sending the completed form in advance will save you time on admission. If you are uncertain about any questions, you can discuss them with one of us.

I. CURRENT SITUATION

A.

	ALONE	NEEDS HELP	UNABLE
1. Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Washing hands and face	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Bathing and skin care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Getting in and out of bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Getting in and out of a chair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Hair care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Fingernail care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Toenail care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Shaving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Brushing teeth and/or dentures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Toilet use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Bowel control:	<input type="checkbox"/> Normal <input type="checkbox"/> Enemas	<input type="checkbox"/> Occasional loss of control <input type="checkbox"/> Uses Suppositories	<input type="checkbox"/> Unable to control

Frequency_____ Time of Day_____

Any "help" used:

13. Bladder control: ☐Normal ☐Occasional loss of control ☐Unable to control
☐Catheter

Frequency_____ Time of Day_____

B. Walking (check all that apply)

<input type="checkbox"/> Normal	<input type="checkbox"/> Cane(s)	<input type="checkbox"/> Wheel Chair
<input type="checkbox"/> Slow but steady	<input type="checkbox"/> Crutch(es)	<input type="checkbox"/> Brace
<input type="checkbox"/> Unsteady	<input type="checkbox"/> Walker	<input type="checkbox"/> Artificial Limb
<input type="checkbox"/> Not walking	<input type="checkbox"/> Climb Stairs	
<input type="checkbox"/> Up in chair only	<input type="checkbox"/> Bedridden	

Resident Name_____ Physician_____ Date_____

Describe falls or injuries resident has had:_____

Name preferred to be called:_____

C. Eating:

1. Foods resident dislikes: _____

2. Foods which cause allergies: _____

Foods which cause indigestion: _____

3. Appetite (check one) ☐ poor ☐ normal ☐ overeats4. Eating (check one) ☐ feeds self ☐ needs help ☐ spoon fed ☐ tube fed

5. Describe use of alcoholic drinks: _____

Any objections to alcoholic drinks prescribed by physician? _____

6. Does resident smoke? _____ If yes, state type & supply: _____

Does he/she object to being with those who smoke? _____

D. Sleeping (check all that apply)

Usual bedtime at: _____ P.M. Usually wake-up time: _____ A.M. If takes nap, time: _____

☐ restless☐ wandering at night☐ unable to use nurse call signal☐ daytime dozing☐ needs side rails

E. Describe any impairments or problems:

1. Speech: _____

If impaired, how does resident communicate? _____

2. Writing: _____

☐ right handed ☐ left handed ☐ both

3. Vision: _____

☐ glasses Reading ability: _____

4. Hearing: _____ Better ear: _____

☐ hearing aid Type: _____

Battery #: _____ Where to buy batteries: _____

Where to get hearing aid repaired: _____

5. Teeth and mouth: _____ Upper ☐ Lower ☐ Dentures ☐

6. Skin: _____

Bedsores: _____

7. Feet: _____

8. Other physical conditions requiring care: _____

9. Problems getting resident to take medicine or treatment: _____

10. Medicines or treatment resident has reacted unfavorably to or is allergic to: _____

F. Check all of the following which describe present condition(s). (If occur only occasionally, indicate when)

Star (*) items developed in recent month(s).

☐ Sociable☐ Hearing things that are not there☐ Slightly forgetful☐ Cheerful☐ Prefers to be alone☐ Very forgetful☐ Independent☐ Prefers groups☐ Depressed☐ Too independent☐ Silent☐ Often angry☐ Mentally alert☐ Cooperative☐ Worrier☐ Confused☐ Reserved☐ Easily fatigued☐ Temper outbursts☐ Aggressive☐ Fears of death☐ Cries easily☐ Has talked of suicide☐ Dizziness☐ Excessive laughing☐ Has attempted suicide☐ Fainting☐ Wants to get well☐ Withdrawn☐ Convulsions☐ Noisy☐ Chronic complainer☐ Headaches☐ Loss of self esteem☐ Sensitive☐ Poor judgement☐ Believes people are against them☐ Sees things not there

II. PAST LIFE

A. Early family life

1. Born and raised: _____

(If foreign born) Age came to U.S. _____ Citizen now? _____

2. Father's name: _____ Birthplace: _____

3. Mother's maiden name: _____ Birthplace: _____

4. Names, age and descriptions of brothers and sisters of resident and present contact and relationship with resident: _____

B. Education
Grade completed: _____ On-the-job training: _____

C. Occupation
Main jobs: _____

D. Travels - where and when? _____

E. Retirement

1. Planning in advance: _____

2. Date of retirement: _____ Voluntary or Involuntary: _____

3. Reaction of retirement was: _____

4. Work subsequent to retirement: _____

F. Marriage (If wife, give maiden name)

1. Spouse's name: _____

2. Date of marriage: _____

3. Divorced? _____ Widowed? _____

4. Reaction to death of spouse: _____

5. Describe the important characteristics of the marriage as you know them: _____

6. Children:

Name: _____ Spouse's name: _____

Grandchildren: _____

Present contacts and relationships with resident: _____

Name: _____ Spouse's name: _____

Grandchildren: _____

Present contacts and relationships with resident: _____

Name: _____ Spouse's name: _____

Grandchildren: _____

Present contacts and relationships with resident: _____

Name: _____ Spouse's name: _____

Grandchildren: _____

Present contacts and relationships with resident: _____

A. Resident's mental/emotional status:

- 1. Are there any problems we can expect? Suggestions for handling? _____

- 2. How does resident accept reality? _____
- 3. What was resident's usual temperament or disposition during earlier adult life? _____

- 4. How is the present temperament of mental attitude of the resident different from the past?
(For example: how do they get along with people? What upsets them?) _____

- 5. What satisfaction does resident have in present life? _____

- 6. What frustrations? _____

- 7. Any medicine resident uses regularly? _____

B. Admission Decision

- 1. Describe in your own words why resident is coming into the facility. Include details that you consider significant: _____

- 2. Who was most influential in making the final decision and how did this come about? _____

III. PRESENT LIVING ARRANGEMENTS

- 1. Resident is presently located? _____ How long? _____

Owned their home? _____ Any plans to dispose of home? _____

Where lived most of adult life? _____
- 2. Whom does resident trust most? _____ The least? _____
- 3. Are there any financial problems the resident is worried about? _____

Can resident manage own pocket money? _____ How much? _____
- 4. Able to take care of own valuables? (Watch, rings, etc.) _____

Precautions: _____

IV. MISCELLANEOUS CURRENT INFORMATION

- 1. What has resident been told about their condition and the outlook for the future? _____

What was his/her reaction? _____
- 2. What has resident been told about coming into the facility? _____

- 3. In the event resident improves sufficiently to be discharged, the tentative plan is that resident will
be moved to: Own Home _____ Sheltered care home _____

Home of family member (name) _____

Home for the aged _____ Foster home _____

Other _____ No plan _____

What has resident been told about these plans and what is their reaction? _____

Where would they prefer to live? _____

Is there any other information you think we should know to assist us in caring for him/her? _____

Admission Date _____ Completed by _____ Date _____

Reviewed by _____ Date _____